Provider Set-Up Form for PAP Therapy
Sleep Management Program
Fax # (866) 501-4668

Date of Set-Up:_____ **Set-Up Performed at:** _____

Patient and Physician Information

Patient Name	D.O.B.	Physician Name	Physician Phone

Address	

Patient Primary Contact #	Patient Email Address

Patient Secondary Contact #	Patient Emergency Contact Name & Phone

Equipment Provided

PAP Devices and Settings

☐**CPAP**: EPAP_____cmH2O

☐**Auto PAP**: Min_____cmH2O Max_____cmH2O

☐**Bi-Level**: EPAP_____cmH2O / IPAP_____cmH2O

☐**Auto Bi-Level**: Min EPAP_____cmH2O Max IPAP_____cmH2O

☐**Bi-Level ST**: IPAP Min_____cmH2O Max_____cmH2O RR: _____

☐**Auto SV**: IPAP Min_____cmH2O Max_____cmH2O
EPAP_____cmH2O

Rate: ☐Off ☐Auto ☐_____ ***Any other settings appropriate (Flex, Ramp, etc.)***

☐**Initial Unit** ☐**Replacement Unit**

Make & Model:

Serial Number:

Humidifier: ☐Heated ☐Cool/Passover

Mask: ☐Nasal Pillows ☐Nasal ☐Full

Mask Type/Name:

Mask Size: ☐S ☐M ☐L ☐XL

☐Other: _____

Compliance Measurement ☐Card ☐Modem/Wireless ☐USB	Wireless ID #	Patient Email Address Entered in Monitoring Site:

SMS Tagged as "Primary Care Physician" or "Sleep Doctor" in Monitoring Site and Granted Authorized User Status

☐Yes ☐No ☐Unknown

Therapy Adherence Agreement:

By signing below, I am indicating my agreement to be an active participant in the CareCentrix Sleep Management iComply Therapy Adherence Program. I understand and agree that my PAP therapy data can be shared with my treating physician, my PAP provider, and CareCentrix to assist with my PAP therapy and adherence. I also agree that I may be contacted by phone, text or email at the phone numbers and email address listed above, including but not limited to, for purposes of helping ensure I am receiving the appropriate support for my PAP therapy adherence. I understand that adherence is defined as using my prescribed equipment a minimum of 70% of nights for an average of 4 hours per night. Unless otherwise noted below, I also give CareCentrix and their staff permission to leave detailed messages regarding my PAP therapy at the phone numbers and email address documented above.

☐ I DO NOT give CareCentrix permission to leave detailed messages regarding my sleep therapy.

Additional comments for CareCentrix iComply Team:

Patient Signature	Date

Provider Name	Signature Company Representative	Date